South Carolina Legislative Audit Council

LAC

Report to the General Assembly

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A Review of Compliance With Our 1983 Audit of the Department of Mental Health and Other Issues

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Legislative Audit Council

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A Review of Compliance With Our 1983 Audit of the Department of Mental Health and Other Issues

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Major Findings

Management of the South Carolina Department of Mental Health (DMH) has implemented policies to address many of the problems cited in our 1983 review. We noted considerable improvement in the department's handling and reporting of patient abuse cases. Since 1983, department security operations have been centralized. There have been improvements in debt collections in the community mental health centers. Also, we did not find the overall problems of patient neglect or abuse that we found in 1983. DMH has made progress in correcting many of the problems we previously reported. However, further corrective actions are needed in some areas.

Some of the policies established by DMH management to resolve problems we identified in 1983 have not been adhered to. In addition, the agency has expanded or implemented new programs without adequate planning or sufficient funding. For these and other reasons, which are addressed in this review, the agency has experienced severe budget deficits.

While the Department of Mental Health has generally made an effort to comply with previous recommendations, problems were found. Major findings in specific areas are summarized below.

Follow-up of Previous Findings

We examined compliance with our 1983 audit and found the following:

- The number of patients leaving DMH facilities without permission (LWPs) has declined since 1983. However, the agency continues to have problems with patients leaving DMH campuses without permission (see p. 9).

- Against department policy, necessary records on employees requesting new keys or lock changes for psychiatric wards and facilities have not been forwarded to the public safety division (see p. 11). A need exists for more stringent internal controls on key and lock requests.

- The unauthorized use of alcohol and drugs are a problem on DMH inpatient campuses. The department, as recommended in 1983, should continue to take steps to eliminate the supply of this contraband to clients (see p. 14).

- DMH continues to have problems with the commitment of patients who are not mentally ill or who do not require inpatient treatment (see p. 17).

- Although DMH has developed measures to decrease the number of patients transported from inpatient facilities to their home counties for commitment examinations and hearings, patient travel for these purposes still presents problems for patients and staff (see p. 22).

- DMH continues to allow some employees to occupy DMH housing at reduced or no cost (see p. 26).

- DMH has not used a funding formula developed to allocate funds to the community mental health centers as required by appropriation acts since FY 85-86 (see p. 29).

- DMH has not followed an agency policy for discharge planning which was designed to ensure continued treatment for patients discharged from inpatient facilities to communities (see p. 30).

Client Services

We reviewed programs which have been implemented since 1983. Several problems were found.

- The justice consent decree is an agreement between DMH and the U.S. Department of Justice in which DMH agreed to correct specific deficiencies at South Carolina State Hospital. DMH has not maintained records which show how special state appropriations, totaling $14.68 million since 1986, were expended to comply with this decree (see p. 33).

- DMH decided to continue the mobile crisis program of the Charleston Area Mental Health Center even though this program has not achieved specific objectives (see p. 36).

- DMH implemented four programs in assertive community treatment (PACTs) to assist clients to live in the communities. The goal of the first PACT was to reduce the census at South Carolina State Hospital by 120 clients by February 1988. Although four PACTs have been established, the census at SCSH has only been reduced by 45 clients (see p. 38).

- DMH did not provide adequate financial planning for the expansion of PACTs. The agency was not aware that it had to provide the state's share for services under medicaid, estimated to total $698,000 for FY 87-88 and FY 88-89 and discontinued statewide expansion when it learned of its financial obligation (see p. 39).

- DMH has expanded the involuntary alcohol and drug treatment program beyond legislative intent and funding. Although the General Assembly approved funding of approximately $2.1 million in FY 88-89 for this program, the agency expended over $6.8 million. As a result, the voluntary alcohol and drug treatment program has suffered (see p. 41).

Budget Deficits

Although state appropriations for the Department of Mental Health have increased by $70 million (82%) over five years, DMH has incurred budget deficits totaling over $16 million for four of the last five years. Our review of DMH's budget revealed the following:

- Budget deficits have resulted in part from the implementation of new, costly programs which have not been effective in reducing DMH's inpatient population (see p. 49), and from an expansion of services without funding (see p. 51). In addition, the agency incurs expenses which are beyond its control (see p. 52).

- At the beginning of FY 88-89, a DMH budget committee advised management to implement 15 recommendations to save $3.4 million to avoid ending the year with a deficit. Because management only implemented 3 measures for a savings of $363,000, the agency finished the year with a $5.1 million deficit (see p. 54).

Conclusion

The Department of Mental Health has made progress in addressing problems that we cited in 1983 and should continue to implement corrective actions. However, the agency has expended funds which were not appropriated, creating major budget problems. The agency must be committed to providing a base level of services that it can afford. DMH management should consider the availability of funding before beginning or expanding programs and provide only the level of services funded by the General Assembly.

Introduction and Background

Previous Reviews of DMH

This is our third review of aspects of the Department of Mental Health. In a 1983 report entitled *A Management and Performance Review of the South Carolina Department of Mental Health*, we found that the department should be more accountable to the General Assembly and responsive to sound management principles, state laws and regulations. In a 1988 report entitled *A Limited-Scope Review of the South Carolina Department of Mental Health*, we examined three contracts executed by the department, the commissioner's travel and the commissioner's use of compensatory time.

Audit Request and Objectives

Members of the General Assembly requested us to conduct a broad-scope review of the South Carolina Department of Mental Health. The major objective of this review was to follow-up on department problems identified in our 1983 audit. In addition, we analyzed the impact of some client services implemented since 1983 and budget deficits incurred by the department in recent years.

Scope and Methods

In conducting this review, we interviewed officials of DMH, other state agencies (within and outside of South Carolina), and the federal government. Also, documents maintained by the Department of Mental Health and other state and federal agencies were reviewed. Specific sampling methodologies were used in individual audit areas, as applicable.

This review primarily covers department activities from July 1, 1985 to June 30, 1989. However, when examining the department's budget, we reviewed information from FY 84-85 to FY 88-89. This report was prepared in accordance with generally accepted government auditing standards.

Internal Controls Review

A specific review of all internal management controls was not an objective of this audit. However, some agency controls were evaluated as a part of the audit objectives. Internal controls instituted by DMH to ensure compliance with major recommendations in our 1983 audit report were tested. Controls were assessed by reviewing system features and documentation, as well as limited testing of compliance. We also tested certain controls to ensure DMH compliance with state laws and agency policies.

Background

The South Carolina Department of Mental Health began in 1821 as the South Carolina Lunatic Asylum with the passage of Act 2269. In FY 88-89, the department served approximately 12,500 patients in 9 inpatient facilities which include:

- South Carolina State Hospital (SCSH);
- Crafts-Farrow State Hospital (CFSH);
- William S. Hall Psychiatric Institute (Hall Institute or WSHPI);
- G. Werber Bryan Psychiatric Hospital (Bryan Hospital);
- Dowdy-Gardner Nursing Care Center (Dowdy-Gardner);
- Earle E. Morris, Jr. Alcohol and Drug Treatment Center (Morris Village);
- James F. Byrnes Medical Center (Byrnes Medical Center);
- C. M. Tucker, Jr. Human Resources Center (Tucker Center);
- Patrick B. Harris Psychiatric Hospital (Harris Hospital).

All of the inpatient facilities except Harris Hospital (in Anderson) and a unit of Dowdy-Gardner (in Rock Hill) are

located in Columbia. In addition, there are 17 mental health centers across the state to provide community treatment for the mentally ill.

DMH's budget, including state, federal and other funds has increased from approximately $131 million in FY 84-85 to approximately $225 million in FY 88-89. The number of authorized personnel has increased from approximately 5,575 in FY 84-85 to approximately 6,600 in FY 88-89.

The South Carolina Mental Health Commission, the department's governing body, is composed of seven members who are appointed by the Governor with Senate approval. The commission determines policies and regulations for the agency's administrative offices, inpatient facilities and community mental health centers. Each commissioner serves a five-year term.

Follow-up of 1983 Audit

This chapter is follow-up of major findings and recommendations contained in our 1983 audit entitled *A Management and Performance Review of the South Carolina Department of Mental Health.* Areas reviewed include patient care, security issues, patient management, property management and community mental health centers.

Oversight of Patient Care

In our 1983 report, we examined the department's handling of patient abuse cases and found problems in several areas. This section will discuss what was found during our current review.

Patient Abuse Investigations

Management has made substantial progress in correcting deficiencies we found in the handling of patient abuse cases. In our 1983 review of DMH, we found problems with the methods of reporting and investigating patient abuse. Based on evidence we reviewed, patient abuse cases are now being reported to the proper authorities within and outside the department, and investigations have generally been thorough. However, DMH's division of public safety has not completed all patient abuse investigations within ten days as required by DMH Directive 584-82.

In a random sample of 104 of 224 (46%) of the patient abuse cases reported to and investigated by public safety in FY 87-88, 28 (27%) were not completed within ten days of when the alleged abuse was reported. In 12 of the 28 cases, investigations were not completed until more than one month after the incident was reported. For example, one patient abuse incident was reported in October 1987 alleging that a patient was struck and injured by a DMH employee. However, interviews with individuals involved were not concluded until more than five months later, and the investigative report was not completed until April 1988.

DMH Directive 584-82 on abusive and neglectful conduct toward patients requires the division of public safety to promptly begin an investigation when an incident is reported. The policy states:

> The investigation shall be concluded as promptly as possible but in no event later than ten (10) work days except in extenuating circumstances.

This requirement is also included in the DMH investigations manual. However, no documentation of extenuating circumstances was found in the 28 files of the cases which required more than ten days to investigate.

A DMH public safety official stated that these patient abuse investigations have not been completed within the required ten days because of a shortage of investigators. However, when investigations are not completed in a timely manner, there is less assurance that the facts in an alleged patient abuse case will be reported accurately. As a result, actual cases of patient abuse may not be substantiated or proper disciplinary action taken against the individuals involved.

Recommendations

1 The Department of Mental Health should ensure that all patient abuse incidents are investigated within ten days as required by department policy.

2 If extenuating circumstances exist such that patient abuse investigations cannot be completed within ten days, the investigation files should document the reasons for delay.

Inquiry and Review Boards

We examined DMH's methods of reviewing "adverse incidents" and patient care issues. The agency convenes either a board of inquiry (BOI) or a quality care review board (QCRB) to review these issues. All BOI and QCRB reports are confidential. A BOI may be conducted by a mental health facility or center staff in the occurrence of adverse incidents such as sudden patient deaths, suicides, deaths due to patient abuse, serious injuries and other areas related to patient care.

The QCRB process has been created since our 1983 DMH audit. QCRB reviews are conducted at the department level (through the division of quality assurance) and may focus on agency-wide patient care issues as well as adverse incidents. Further, a QCRB may be convened as a result of a board of inquiry.

In 1983, we found that the department was not reporting possible illegal activities, documented in BOI reports, to outside authorities. We also found problems with the membership of the BOIs.

During this audit, a review of BOIs did not reveal problems with the department's reporting of questionable incidents. However, problems were found with the membership of the BOIs. Additionally, the department has not developed a policy for BOIs. Further, DMH has not ensured that recommendations from the QCRB reviews are implemented. These areas are discussed in detail below.

BOI Membership

In 1983, the boards of inquiry were comprised entirely of DMH employees. We recommended that the boards include public members not affiliated with DMH to provide a more balanced approach to evaluating problems. DMH has not implemented this recommendation. Instead of allowing outside participation on the BOIs, the department created a second process of case review (the quality care review boards) in which persons other than DMH employees are allowed to participate.

Quality care review boards have authority to review the findings of BOIs. However, in 1987 and 1988, only three QCRBs were convened as a result of BOI reviews conducted during this same time period. This means that approximately 99% (201 of 204) of the BOIs conducted during this period were reviewed by boards made up entirely of DMH staff.

Membership of persons outside of the department would provide a balanced approach to evaluating problems in the mental health facilities and centers.

BOI Policy

There is not an agency-wide policy for conducting BOIs. Some of the facilities and centers have established their own internal policies while others use the DMH policy on QCRBs. This has resulted in inconsistencies in BOIs conducted among the 9 mental health facilities and the 17 community centers.

A random sample of 73 of 204 of the BOIs conducted in 1987 and 1988 found inconsistencies in the number of members assigned to the boards, composition of the reports, and whether or not the reports were signed by board members. Also, some BOIs may have been conducted by only the treating physician of the case in question. Without specifications about the composition of the board, individuals involved in the questionable treatment of a client may review their own cases, presenting a potential conflict of interest.

Follow-up on Recommendations

Management implemented Directive 704-87 which states that the senior deputy commissioner of clinical services is to monitor implementation of recommendations from the quality care review boards. However, the department has not established formal procedures to ensure follow-up on these recommendations in order to resolve patient care problems.

Department records we reviewed did not show evidence that QCRB recommendations have been implemented. Also, outside parties who have been involved in the QCRB process informed the Council that the same problems and recommendations are noted from one QCRB to another.

DMH officials stated that there has been follow-up on the QCRB recommendations. However, according to these officials, follow-up has not been documented. Without formal procedures for follow-up on QCRB recommendations, there is less assurance that patient care problems have been resolved.

Recommendations

3 The Department of Mental Health should consider enacting a policy which provides for a designated number of persons other than department employees to participate in board of inquiry case reviews.

4 The Department of Mental Health should develop a policy for conducting boards of inquiry.

5 The Department of Mental Health should consider exempting employees involved in the "adverse situation" as well as management of a facility or center from serving on boards of inquiry.

6 The Department of Mental Health should implement formal procedures for follow-up on quality care review board recommendations.

Reporting of Patient Sexual Abuse

Management has made substantial improvements in the handling of patient sexual abuse cases. In 1983, we found that DMH failed to cooperate fully with the solicitor's office in the prosecution of sexual assault patient abuse cases. In our current review, we found that the department is consistently notifying the proper authorities with regard to patient sexual assault. In addition, DMH is taking appropriate actions against employees involved in sexual assaults and is cooperating with the solicitor's office in the prosecution of employees involved in the sexual assault of patients.

We reviewed all 77 reports of patient sex incidents which occurred between July 1, 1987 and June 30, 1988. Of the 77 incidents, 45 involved a patient with another patient(s) and 32 involved a patient and a nonpatient (i.e. employee, visitor, etc.). Of those 32, there were eight substantiated cases involving six different DMH employees. One employee was prosecuted for three separate incidents. The remaining five incidents resulted in the suspension of three employees, the termination of one

employee and the prosecution of one employee. In all instances, the decision to prosecute was made by the solicitor's office.

Patient Security

In 1983, we reviewed DMH police and investigative records and found that patients were not adequately protected. We reviewed these same areas in this review and found the following.

Leave Without Permission From In-Patient Facilities

Since our 1983 review of DMH, the number of patients leaving without permission (LWPs) from South Carolina State Hospital, Hall Institute, Bryan Hospital and Crafts-Farrow State Hospital has decreased. In 1983, we recommended that DMH more closely monitor the issuance of off-ward privileges and close hospital gates.

For three of the DMH facilities reviewed in our last audit (South Carolina State Hospital, Hall Institute and Bryan Hospital), we found a lower percentage of patients leaving without permission. For FY 80-81 and FY 81-82, the percentages of patients leaving without permission compared to the average daily census were 18% and 28% respectively, as compared to 13% for FY 87-88. We also found that LWPs at Crafts-Farrow State Hospital remained at less than 1% for all years reviewed.

In the 9 inpatient DMH facilities, there were 186 incidents of patients leaving without permission in FY 87-88, involving 263 patients. To determine whether improper issuance of off-ward privileges continued to be a problem, we conducted a systematic random sample of 97 of the 186 (52%) LWP incidents. Of the 97 LWP incidents reviewed, 23 (24%) were attributed to abuse of off-ward privileges. Other incidents involved patients climbing out of windows, walking away from groups or buildings, or leaving hospitals by unknown means.

Two incidents involving abuse of off-ward privileges (yard cards) are as follows:

- A patient who was involuntarily committed to the state hospital left the facility with a yard card. This patient's mother called to inform the state hospital that her son was at home and wanted to find out why.

- An involuntary mental patient at Bryan Hospital failed to return from pass. The agency's incident report listed the patient as being "dangerous to himself and others if not on medication."

Although fewer patients were found to be leaving DMH campuses without permission, there has been no definable change in procedure regarding the prevention and containment of patients leaving without permission.

Recommendation

7 DMH management should continue to evaluate criteria used in issuing yard cards to ensure that only patients with a minimum risk of escaping are issued a card.

Unattended Wards

We found that since 1983, management has ensured that patients are better supervised. In 1983, we found 20 substantiated incidents of patients being left unsupervised either because employees slept on duty or left their wards unattended. One recommendation we made to deter these incidents was to have management conduct "surprise" inspections on the wards. Another recommendation was to more strictly and consistently discipline employees who committed these violations.

In this review, we selected a systematic random sample of 124 of the 248 (50%) employee policy violations for January 1987 through May 1989. This category included employees sleeping on the job and leaving wards unattended. We found 9 substantiated incidents (involving 14 employees) of employees sleeping on the job and no incidents of employees leaving wards unattended. According to DMH Directive 627-83, *Standards of*

Disciplinary Action, the first offense for sleeping on the job is a written warning to three days suspension. The penalty for the second offense is dismissal. The disciplinary action applied to five employees was in compliance with the department's directive on standards for disciplinary actions. However, for nine employees, there is no documentation of disciplinary action.

There is no indication from the incident reports that "surprise" inspections are being conducted; however, 13 of the 14 employees cited in substantiated incidents of sleeping on the job were observed by public safety officers on routine foot patrol. Further, while there was no direct patient harm because of these incidents, this type of neglect may jeopardize the welfare and safety of patients.

Recommendation

8 DMH should ensure that employees found violating DMH policy are properly disciplined. Documentation of disciplinary action such as notices of suspension and notices of dismissal should be forwarded to the central personnel office from the facility where the incident occurred.

Key Control

Since our 1983 audit of DMH, management has taken steps to control the distribution of keys. DMH Directive 624-83, *Key/Lock Control*, outlines the responsibilities of physical plant services, public safety and the inpatient facilities to ensure proper key and lock control. This directive requires each facility to have an internal key control policy and requires that a copy of all requests be sent to public safety. In 1983, we reported problems with insufficient records at DMH which documented assignment of keys, the number of lost keys and whether terminated employees turned in their keys. Recommendations included implementing more stringent policies for key control to ensure a sound security system and assigning a key custodian at each facility to handle key control.

Since 1983, management has required that each facility establish a person or persons to serve as key custodian and there has been overall improvement in the maintenance of records. However, we found several compliance problems with department policy which include:

- Two of the facilities have not established an internal key control policy.
- Only two facilities have consistently forwarded a copy of all key and lock requests to public safety (this review excludes Harris Hospital).

During FY 87-88, physical plant services received 1,081 key and lock requests from the Columbia area facilities, excluding the northeast facilities. Public safety received only 206 (19%) of these requests. We could not readily compare the key and lock requests received by public safety to those of physical plant services, because a pre-numbered request system is not used. A pre-numbered system would allow the department to more easily reconcile requests received between the two divisions and identify problem areas.

Reasons offered by various facilities as to why a copy of the key and lock requests are not forwarded to public safety include the assumption that physical plant services notifies public safety. Officials from two facilities commented that a copy would be sent to public safety if they deemed the situation to be a potential safety or security risk.

Failure to notify public safety prohibits that office from performing the necessary monitoring of requests. Without proper key and lock control, the safety and security of the department's patients, employees and property is lessened.

Recommendations

9 DMH facilities should adhere to Directive 624-83 and implement an internal key control policy. Further, a copy of all key and lock requests should be sent to public

safety to allow that division to properly monitor the requests and ensure adequate key control.

10 DMH should implement a pre-numbered key request system to strengthen their internal controls over key and lock requests.

Other Security Issues

In 1983, and in this review, we identified security problems resulting from alcohol and drugs on hospital wards. Additionally, in this review we updated the status of DMH security operations and examined security operations at Morris Village.

DMH Security

In 1983, we recommended that DMH security operations be removed from the authority of DMH. Also, security operations were fragmented. Each facility was responsible for its own security and investigative functions with no one person in charge of all operations. There was also concern that management was not notifying outside law enforcement officials concerning incidents of patient abuse, thefts and misuse of state property by department personnel and possible criminal conduct by top agency officials.

Section 23-3-30 of the South Carolina Code of Laws, effective in 1983, placed DMH security under the supervision of the State Law Enforcement Division (SLED). The security and investigative operations have been consolidated into the public safety division of DMH with one coordinator in charge. This consolidation has led to a more centralized and uniform system.

Also, centralization has aided public safety in ensuring that outside law enforcement officials and proper authorities are notified of possible improper activity. Further, SLED has access to all incident reports and investigation reports to ensure that investigations are handled properly and objectively.

Alcohol and Drug Use at DMH Facilities

Since 1983, the overall problems of alcohol and drug usage has decreased. In 1983, we found 216 substantiated incidents of patients or employees consuming or possessing marijuana or alcoholic beverages at DMH facilities over a period of 32 months. (The facilities reviewed did not include Harris Hospital or Morris Village.) Of the 216 incidents, 182 involved patients and 34 involved employees.

In this review, we found 103 substantiated incidents of alcohol and drugs at the nine DMH facilities from January 1987 to May 1989 (29 months). Of the 103 incidents, 83 involved patients and 20 involved employees. Morris Village accounted for 43% of the overall total number of incidents which occurred (see p. 15).

To deter the flow of contraband at DMH facilities, we recommended in 1983 that the department initiate investigations to determine the manner in which patients obtained contraband on the wards. In addition, we recommended that DMH and proper law enforcement authorities coordinate to prosecute any individual possessing contraband on DMH property.

Approximately one-fourth (25) of these incidents from January 1987 to May 1989 were investigated. According to DMH officials, investigations into the source of contraband have been hindered by the inability to search individuals and personal property without probable cause and the lack of sufficient personnel and proper equipment in the public safety division (see p. 15).

Legislation has been introduced to amend §44-52-165 pertaining to contraband. This legislation would make it a crime for DMH patients receiving alcohol and drug treatment services to possess alcoholic beverages, firearms, dangerous weapons, or controlled substances. Further, the department has requested an Attorney General's opinion concerning the applicability of §61-5-30 (unlawful possession and consumption of alcohol) to a DMH facility.

Recommendation

11 The DMH public safety division should attempt to determine the source or supply of alcohol or illicit drugs on DMH grounds.

Morris Village Security

Since the 1987 involuntary commitment law became effective, Morris Village has become primarily an involuntary instead of a voluntary alcohol and drug treatment facility as intended (see p. 41). This has resulted in security problems which include patients leaving without permission and possession of alcohol or unauthorized drugs.

Leave Without Permission

In FY 87-88, 80 of 263 (30%) patients leaving DMH facilities without permission were residents of Morris Village. A public safety official stated that better fencing and lighting and adequate security to patrol the grounds could help minimize the number of patients leaving without permission.

Alcohol and Drugs

Residents of Morris Village have been acquiring alcohol and illicit drugs. A systematic random sample of patient policy violations and a review of all drug violations from January 1987 to May 1989 revealed the following:

- A total of 22 of 31 (71%) of the substantiated incidents involving patient possession or consumption of alcoholic beverages occurred at Morris Village.
- A total of 6 of 34 (18%) of the incidents involving patient possession of illicit drugs occurred at Morris Village.

To curb the problem of alcohol usage, a procedure was established in March 1988 to enable public safety to arrest and charge any intoxicated client with disorderly conduct under §16-17-530 of the South Carolina Code of Laws. However,

public safety officers stated that they cannot arrest clients for possession of alcohol, unless they are intoxicated (see p. 14).

DMH officials stated that some contraband is being supplied by visitors to the facility. According to these officials, visitors are searched by hand scanners which detect metal but not drugs or alcohol.

In December 1986, public safety officials were advised by DMH legal counsel of search procedures. Public safety officials interpreted these procedures to mean that they could not search visitors without probable cause, consent, or incident to criminal arrest, and discontinued random searches. Public safety then adopted a policy for the northeast facilities (including Morris Village) to limit contraband searches to instances where there was written consent or probable cause. The implementation of this policy led to a decrease in the number of contraband searches conducted.

In August 1989, public safety requested DMH legal counsel to examine the contraband policy to determine areas where changes can be made regarding contraband searches. According to an official of the legal division, public safety can conduct random searches under certain conditions. However, as of January 1990, searches except for one using a trained dog, had not been conducted. Random searches could lead to an increase in the number of contraband searches conducted and thus, could help to deter contraband traffic.

Recommendations

12 The General Assembly may wish to consider amending §44-52-165 to provide penalties for patients in alcohol and drug treatment programs who possess contraband.

13 DMH should consider increasing security measures at Morris Village such as installing fencing and lighting around the grounds and allocating more public safety division officers to properly protect the staff, patients and visitors.

14 The DMH public safety division should conduct random searches as a means to reduce contraband.

Patient Management

Several administrative problems reviewed in 1983 were examined during this review. These include the admission of persons to DMH facilities who do not meet admission criteria and the transporting of patients to commitment hearings and examinations. These areas are discussed in detail below.

Inappropriate Admissions

In our 1983 report, we found that the Department of Mental Health had problems with inappropriate admissions to its inpatient facilities. The department still has problems with inappropriate admissions, although not as serious as we reported in 1983. DMH officials reviewed admissions to five facilities and provided us with information on those considered inappropriate. These admissions were divided into two groups, general inappropriate admissions and medically inappropriate admissions.

General inappropriate admissions include individuals who show no evidence of mental illness, individuals who are mentally retarded, and individuals with various mental disorders who could be treated adequately on an outpatient basis. Some individuals with medical problems also fall into this category, as well as individuals needing DMH services but who are admitted to the wrong facility.

Medically inappropriate admissions consist of individuals who primarily have a physical rather than a mental disorder and are transferred to a private hospital within ten days of admissions.

General Inappropriate Admissions

Individuals are admitted to DMH facilities for mental health care which is not needed or could be provided in a less restrictive environment. DMH officials reviewed admissions to South Carolina State Hospital, Bryan Hospital, Crafts-Farrow State

Hospital, Harris Hospital, and Morris Village from May 1, 1988 through July 31, 1988 to determine inappropriate admissions. During this time, 372 of 2,821 (13%) admissions were considered inappropriate to the admitting facility. However, 185 of the inappropriate admissions could have been served at another more appropriate DMH facility if bed space had been available.

According to DMH officials, 127 of the remaining 187 (68%) admissions, inappropriate to all DMH facilities, could have been served on an outpatient basis at a community mental health center or a local alcohol and drug treatment center. Another 25 (13%) had an overriding medical problem which could have been treated in the community. No mental health services were needed for 20 (11%) of the individuals, who had no mental illness (see Table 2.1).

Table 2.1: Number and Percentage of Inappropriate Admissions to All DMH Facilities, May - July 1988

	Inappropriate Admissions	
Category	Number	Percent Total
Treatable as Outpatient	127	68
Overriding Medical Problem	25	13
Not in Need of Mental Health Services	20	11
Other	15	8
Total	**187**	**100**

Source: Department of Mental Health

Medically Inappropriate Admissions

Individuals are being admitted to DMH facilities who have primarily a physical rather than a mental disorder or an alcohol or drug abuse problem. These patients include individuals who may show evidence of mental illness, but in whom a mental disorder is secondary to the medical or physical disorder.

DMH officials have stated that the transfer of a patient from a facility to a medical unit within ten days of admission may indicate an inappropriate admission. According to DMH records, 74 patients admitted to DMH facilities during FY 87-88 were transferred to a private hospital within 10 days of admission. DMH officials reviewed these cases and determined 50

admissions (68%) were medically inappropriate and cost the department approximately $192,000, after third-party reimbursement. DMH provided the following examples of medically inappropriate admissions:

- A patient was transferred to a private hospital six days after admission to Bryan Hospital for bleeding from a membrane of the brain and spinal cord. She remained in the private hospital until she died. Her hospitalization cost the department over $115,000.

- Another patient was admitted to Morris Village with drainage from a collapsed lung. The patient was transferred to Byrnes Medical Center and then to a private hospital, three days after his admission. His hospitalization cost DMH approximately $14,000.

DMH officials indicated that they have been working with medical officials in the communities to lower the number of medically inappropriate admissions. According to DMH officials, medically inappropriate admissions have decreased.

Admission Criteria

Since our 1983 report, several legislative changes pertaining to admissions to DMH have occurred. The General Assembly enacted community screening legislation for admissions to DMH facilities which became effective September 15, 1988. Community screening is intended to make the community mental health centers the entry point for mental health services. The legislation requires physicians to "consult " with community mental health centers regarding the commitment and admission process and the treatment alternatives available in lieu of inpatient commitment. However, physicians are allowed to commit an individual *without* consulting a mental health center, if a clinical reason for this admission is stated on the admission form. Therefore, the mental health center is not required to evaluate individuals to ensure that the individual is mentally ill or chemically dependent and in need of inpatient commitment.

Florida, Georgia, North Carolina, Tennessee, and Virginia all require that patients being involuntarily committed be first

evaluated by either a state facility or a community mental health center. This evaluation is to determine the need for inpatient hospitalization instead of treatment in the community. For example, Florida directs its Department of Health and Rehabilitative Services to ensure that no patient is admitted to a state facility unless he has previously been evaluated and found to meet the criteria for admission by a community-based mental health center.

Sections 44-17-310, 44-17-410, 44-17-510, 44-52-20, 44-52-50, and 44-52-70 of the South Carolina Code of Laws define the criteria for voluntary, emergency, and judicial commitment to state mental health and alcohol and drug abuse facilities. These laws do not provide the department with specific authority to deny inappropriate admissions, although DMH can refuse to accept an involuntary alcohol and drug admission if bed space is not available (see p. 41). State psychiatric facilities in Georgia, Florida, North Carolina, and Tennessee are authorized to discharge patients who do not meet inpatient commitment criteria prior to the hearing.

Another legislative change occurred in 1986 when §44-17-410 was amended to require DMH facilities to submit to the court the names of two designated examiners when someone has been admitted to a psychiatric facility through emergency provisions. The designated examiners appointed by the court are to evaluate and report to the court whether or not the individual is mentally ill and in need of inpatient commitment. The report must be written within seven days. If no mental illness is found, the individual is discharged and the proceedings are dismissed. If mental illness is found, a commitment hearing must be held within 20 days of admission.

According to DMH officials, this amendment has helped to release emergency commitments who do not need DMH services. During FY 87-88, 398 patients were ordered released by the probate courts within 9 days of admissions.

Commitment Statutes

South Carolina statutes do not allow patients who are involuntarily committed to change their commitment status to voluntary. If this were allowed, it would eliminate the need for certain commitment hearings and decrease the costs of judicial proceedings.

We found that Florida, Georgia, Tennessee, and Virginia allow conversion of the admission status from involuntary to voluntary.

In addition, South Carolina requires commitment hearings to be held within 20 days of admission to a state facility. This exceeds the requirement in North Carolina, Virginia, and Florida. North Carolina requires hearings to be held within ten days, and Florida requires a hearing within five days of the physician's examination. Virginia requires commitment hearings within 48 hours, unless the patient retains counsel, in which case a hearing is required within a reasonable time.

Conclusion

Although individuals continue to be inappropriately admitted to Department of Mental Health facilities, there has been improvement in recent years. Inappropriate admissions happen, in part, because DMH facilities cannot discharge an individual who is involuntarily committed even if the DMH physicians determine that there is not a need for inpatient commitment. In addition, while community screening by the mental health centers is not mandatory, it has helped to reduce inappropriate admissions. Reducing the number of inappropriate admissions is important in reducing the census of inpatient facilities and the expenses of DMH.

Recommendations

15 The General Assembly may wish to consider amending §44-17-890 to provide DMH facilities with the specific authority to discharge individuals not meeting inpatient admission criteria.

16 The General Assembly may wish to consider amending §44-17-410 to require emergency admission hearings within 10 to 15 days of admission.

17 The General Assembly may wish to consider amending §44-17-450 to require the community mental health centers to screen potential commitments and deny admission for those not meeting inpatient admission criteria.

18 The General Assembly may wish to consider amending §44-17-410 of the South Carolina Code of Laws to provide statutory authority for DMH to change the admission status of a patient from involuntary to voluntary prior to the completion of the involuntary commitment proceedings.

Travel to Probate Hearings

In our 1983 report on the Department of Mental Health, we found that decentralized hearings were an added expense to DMH and could endanger the health, safety and welfare of patients. We recommended that the General Assembly consider amending appropriate statutes to provide for a system of centralized commitment hearings and examinations. While legislation has not been amended, the department has taken steps to reduce the number of patients being transported from Columbia to various counties for examinations and hearings.

To avoid transporting patients to their county of residency for probate hearings, the department has contracted with some probate judges of the patients' residency to conduct hearings at DMH facilities. For FY 89-90, the department has contracts with probate judges from ten counties, including Richland and Anderson counties. DMH agrees to pay the judges $100 for each hearing held for involuntary commitment proceedings, plus travel reimbursement. The department paid $192,200 for these contracts during calendar year 1988 and $95,600 for hearings held between January and May 1989.

According to DMH's quality assurance division statistics, the number of hearings held at DMH facilities has increased. During calendar year 1988, 4,132 of 7,109 (58%) hearings conducted were held at DMH facilities. Between January and April 1989, the percent of hearings held at DMH facilities increased to 74% (1,542 of 2,083).

According to a study performed by Bryan Hospital, 166 trips, totaling 31,898 miles, were taken for probate proceedings at an estimated cost of $50,985, or $308.19 per trip between April and June 1989. According to the director of Bryan Hospital, the costs are substantial to the hospital, but his major concern is patient care. He stated that it is unfair and at times unsafe for a patient to stay away from the hospital for the extended period of time required for some hearings. Further, when hospital staff must accompany patients to hearings, he is faced with an acute staff shortage which is detrimental to the facility and patient care. According to the study by Bryan Hospital, staff was away on probate trips 2,499 hours during these three months.

There is no legal requirement that hearings must take place at the treatment facility or in the locality where a person is being treated. Section 44-17-410 of the South Carolina Code of Laws allows the probate court where the person resides or where the acts occurred to determine the location of the hearing.

Recommendation

19 The Department of Mental Health should continue to work with probate judges to hold hearings at inpatient facilities when appropriate.

Notification of Coroners

In our 1983 audit of DMH, we found that DMH was not properly notifying the coroner of patient deaths. Management has taken steps to correct this problem. In most cases, the Department of Mental Health is notifying the coroner of patient deaths.

During this review, we noted that the department has not requested permission from the deceased patients' families to perform an autopsy as required.

We randomly sampled 127 of 479 (27%) patient deaths occurring at DMH facilities in FY 86-87 and FY 87-88. Of the 127 cases reviewed, the coroner was notified in all but 1 case and ordered 8 autopsies. However, documentation of requests for permission to perform autopsies was found for only 29 of the remaining 119 (24%) patients.

DMH Directive 663-85 states:

> It is the policy of the Department of Mental Health to obtain an autopsy for patients who die at a Departmental facility if approval for same can be obtained from the Coroner or from the patient's family.

The Department of Mental Retardation has a similar policy to conduct an autopsy for each client death, if there is no family objection, and to perform a peer review within ten days. Autopsies allow the physicians to determine the exact cause of death. Further, if questions arise after a patient's death and an autopsy has been performed, these questions might be answered.

Department officials stated that autopsies have not been routinely requested because the request is left to each facility's discretion. Therefore, autopsies have been performed only when the coroner orders one.

Recommendation

20 The Department of Mental Health should follow Directive 663-85 for requesting approval for autopsies in all cases of patient deaths.

Property Management

During the course of this and our 1983 audit, we reviewed the department's handling of property. The following problems were found.

Confiscated Property

In our 1983 review, we found problems with the accountability of confiscated items. During this review, we found that management implemented Directive 637-84, which requires public safety to properly account for and dispose of confiscated items. This directive requires controlled drugs, narcotics, and firearms to be turned over to SLED. All other confiscated items are to be dumped or destroyed at least every two months and witnessed by a representative from the internal audit division.

Although policies have changed, the public safety division has not followed these policies and procedures when accounting for and disposing of confiscated property (contraband). According to an internal audit report, public safety has not conducted regular disposal of confiscated items.

A June 1988 DMH internal audit report found that public safety officials were not disposing of confiscated property every two months as required. Also, an internal auditor was not scheduled to witness the disposal of confiscated items between August 1987 and May 1988. Further, we found that public safety has not accounted for or disposed of confiscated items which have been maintained since at least 1983. These items include more than 150 knives, 3 guns, numerous bags of a grasslike substance, pills, alcohol, and bullets. The items, transferred from a safe at South Carolina State Hospital, are not on the contraband log maintained by public safety. Therefore, a reconciliation could not be made to determine if all items were accounted for. According to the chief of public safety, these items should have been disposed of.

The public safety division has not ensured that Directive 637-84 has been followed. Further, the internal audit division has not periodically conducted audits of confiscated property as recommended in our 1983 report. Because department procedures have not been followed, accountability of confiscated items cannot be ensured and items may be lost, stolen, misplaced, or misused.

Recommendations

21 The Department of Mental Health should follow all agency policies and procedures when accounting for and disposing of confiscated property.

22 The internal audit division should periodically make unannounced inspections of confiscated property and records.

Department Housing

The Department of Mental Health does not charge fair market rental value on agency-owned housing rented to DMH employees. In addition, the commissioner of mental health is provided housing (including utilities) free of charge. As a result, the department lost approximately $56,000 in revenue and spent approximately $4,200 for utilities from FY 86-87 through FY 87-88.

Each appropriation act since at least FY 82-83 has stated:

> That salaries paid to officers and employees of the State, . . . shall be in full for all services rendered, and no perquisites of office or of employment shall be allowed in addition thereto, but such perquisites . . . shall be charged for at the *prevailing local value* . . . . [*Emphasis Added*]

Also, these appropriation acts have exempted specified state officials, such as the commissioner of the Department of Corrections, from paying for housing owned by their respective agencies. However, the commissioner and other employees, except nurses and attendants of mental health are not included in these exemptions.

The department owns five houses and eight apartments which are located off its Columbia campuses. Since FY 86-87, the department's internal audit division has conducted annual reviews to determine the fair market rental values of the properties. Based on its FY 87-88 review, the rental values for housing ranged from $325 to $800. In FY 88-89, the department did not update the fair market values for its houses. However,

the actual rents charged by the department ranged from no charge to $650. For example, two houses having fair market rental values of $600 a month were rented for $300. Further, the estimated rental value of the house occupied by the commissioner at no charge was $800 a month.

Although we recommended in 1983 that the department charge fair market rental values and the cost of utilities on its properties, DMH has not charged these rates. According to a department official, free and reduced housing costs are used as a means to recruit staff. Further, in 1984, the Mental Health Commission approved a housing policy which required the state commissioner of mental health to occupy department housing at no cost. While providing free and reduced housing to key department officials may be a worthwhile means of recruiting and attracting employees, the practice is contrary to state law.

Recommendation

23 The General Assembly may wish to consider amending a proviso concerning DMH owned housing to allow for certain employees to live for free or at reduced prices. If the proviso is not amended, DMH should charge employees the fair market value for housing provided.

Department Surplus Land

In our 1983 review of the Department of Mental Health, we identified two tracts of surplus land totaling 933 acres which were not needed and could be disposed of. The department transferred one tract to the South Carolina Research Authority in 1983, but has maintained another tract of approximately 300 acres which is not needed and could be worth between $1.5 and $2 million.

This property, currently used for recreational purposes, was acquired in the early 1900s in anticipation of the department's growth, but no buildings have been constructed on the property. Further, the department has no written plans for future

development of the 300 acres. The department currently makes the area available to patients and charges employees a fee for fishing and outdoor activities. DMH records show that patients used the recreational area on six occasions in FY 87-88. In FY 88-89, at least 431 DMH patients used the recreational area.

DMH's policy for decentralization of services to community mental health centers results in the department's having little need to maintain the land for expansion purposes. By not disposing of unneeded land, the state is forgoing the potential revenue from its sale which would be credited to the general fund.

Recommendation

24 The Department of Mental Health should dispose of surplus land in a manner most beneficial to the state.

Community Mental Health Centers

In our 1983 review of the Department of Mental Health, we visited six mental health centers to review their operations and their relationships with the inpatient facilities. We found problems in several areas including inadequate funding, inadequate discharge planning, no formula for distribution of funds, no procedure for collection of fees or writing off of bad debts, and no cost effectiveness studies.

During this review, we visited six mental health centers based on expenditures and discharges. The centers visited included Charleston, Columbia, Catawba, Waccamaw, Spartanburg, and Anderson-Oconee-Pickens mental health centers. During our review, we found that mental health center expenditures have increased at a higher percentage than inpatient expenditures as we recommended in our 1983 audit. From FY 85-86 to FY 87-88 community expenditures increased by 48% as compared to 25% for the inpatient facilities. Details of our review follow.

Funding Formula

In our 1983 report, we found that the department was not using a formula when allocating state funds to the mental health centers. Also, the per capita funding among the centers varied from a low of $2.78 to a high of $10.11. In our current review, we found that even though the department has an allocation formula to use for new state funds, it has not always been used. Also, inequities of per capita funding between the mental health centers has increased since 1983. According to comparative financial data from DMH, per capita funding varied from a low of $6.03 to a high of $11.50 in FY 87-88.

According to DMH, the department has had an allocation formula since FY 82-83 which was revised in FY 87-88. We reviewed the use of the formula by the department from FY 85-86 through FY 88-89 and found that a formula was used to allocate funds to the centers from FY 85-86 through FY 87-88. However, funds were not allocated using this formula in FY 88-89. In FY 88-89, 4 of the 17 centers were allocated all additional state funds received by the department based on management decisions.

Appropriation acts since at least FY 85-86 have required the department to distribute all general increases for community mental health centers according to the block grant funds formula. There are no provisions which allow DMH to deviate from the formula, even for just cause. The department developed a funding formula which was designed to:

- Achieve equity in the distribution of funds by population;
- Assure a funding base for general outpatient services;
- Provide incentives for local funding and fund raising; and
- Establish policy in regard to funding reserves.

DMH officials disagree on what is required by the appropriation act and whether or not the formula has been properly applied.

Recommendations

25 The Department of Mental Health should distribute all general state fund increases to the mental health centers by use of the block grant formula as required by the appropriation act.

26 The General Assembly may wish to consider allowing the department to deviate from the formula for just cause.

Discharge Planning

In our 1983 review of the department's planning for patient discharges from inpatient facilities to community mental health centers, we found that there was no policy concerning discharge planning and that discharge information was not consistently sent to the centers. In 1985, DMH management implemented Directive 674-85, which standardized the discharge planning process. However, we found that the facilities do not consistently follow this policy, resulting in inadequate discharge planning. Also, the department has not established a monitoring system as was previously recommended.

We reviewed the files of 202 discharged patients to determine compliance with DMH Directive 674-85. According to the facilities, 43 patients moved or were referred to an alternative source for follow-up services. Of the remaining 159 files, 35 (22%) either had no discharge information or no final summary as required. This is an improvement over 1983, when 55% of the files had no discharge summaries. Also, 13 files were not located for patients who according to the discharge facility were referred to a mental health center.

Directive 674-85 was implemented to establish the necessary elements for discharge planning. Facilities are to notify the appropriate mental health center that a patient has been admitted. Once a discharge is planned, the facility is to notify the mental health center of the date and after discharge, the final summary is to be sent.

DMH is aware of the problems associated with discharge planning and has formed a continuity of care committee to review the process and make recommendations for improvement. Between December 1987 and March 1988, the department secured fax machines for use between the facilities and centers to facilitate discharge planning. Department officials are unsure as to whether or not the fax machines will greatly improve communications about patients. Further, according to DMH officials, there could be better communications with existing resources.

Proper discharge planning is necessary to ensure quality patient care. The mental health centers need information on patients' medical situations and medication to properly treat the patients.

Recommendation

27 The Department of Mental Health should follow Directive 674-85 to ensure proper planning for a patient's discharge from an inpatient facility to a mental health center. Also, a monitoring system should be implemented to assure compliance with this directive.

Cost Variance Reports

In 1983, we recommended that the Department of Mental Health use cost data collected from the centers to evaluate cost variances of services provided by the community mental health centers. According to a DMH status report issued in May 1988:

> DMH has not conducted a study of the utilization of cost data collected from centers and clinics since the '83 LAC Audit recommending this process.

This data could be used to prioritize funding of programs to the centers. DMH officials indicate that they are now collecting information to be used to evaluate costs of community mental health centers.

Recommendation

28 The Department of Mental Health should, on a continuing basis, collect and analyze cost data for community mental health centers.

Collections and Uncollectible Debts

In our 1983 report, we found that DMH had not established policies and procedures for the mental health centers to follow concerning the collection of fees and the write off of uncollectible accounts. In 1984, DMH management established a directive to set a minimum billing standard and a write-off policy for the centers to follow with patient accounts.

We examined the policies and procedures used for collecting and writing off debts by six mental health centers (Columbia, Anderson-Oconee-Pickens, Catawba, Waccamaw, Spartanburg, and Charleston). We found that the centers attempt to collect fees and write-off uncollectible patient accounts. These centers collected $1 million between FY 85-86 and FY 87-88. During this same time period, 5 of 6 centers wrote off debts totaling approximately $312,000. This is an improvement over 1983 when only three centers were reported to write off debts on a regular basis.

Client Services

We examined the implementation of some new client programs at the Department of Mental Health and found that modifications and improvements are needed. Problems with program accountability were identified. Also, some client services are provided in excess of the amount of funding appropriated by the General Assembly. These areas are discussed below.

Justice Consent Decree

Between November 1983 and January 1984, the United States Department of Justice investigated patient conditions at the South Carolina State Hospital (SCSH). This investigation revealed problems with staff to patient ratios, staff qualifications, patient medication, and patient restraints and seclusion.

As a result of the investigation, in June 1986, the Department of Justice and the state of South Carolina, including the Department of Mental Health, entered into a consent decree in which the state agreed to correct deficiencies cited by the Department of Justice. The consent decree includes a settlement agreement and a four-year remedial action plan. The settlement agreement outlines the standards for improvements at SCSH, while the remedial action plan specifies the corrective actions to be taken by DMH.

Both the settlement agreement and the remedial action plan are to be fully implemented by the state on or before July 1, 1990. If the Department of Justice and DMH cannot resolve issues involving the plan, the United States District Court for South Carolina will decide the issues for both parties.

DMH has less than six months remaining to comply with the settlement agreement and the remedial action plan. We found that DMH is unable to determine the amount of state funds expended to comply with the consent decree. Also, DMH and the Department of Justice have conflicting interpretations about a state modification to the remedial action plan. These issues are discussed below.

Funds to Comply With the Justice Consent Decree

The Department of Mental Health has not maintained records which show how special appropriations were expended to comply with the requirements of the consent decree. There are no records detailing exactly how special appropriations of $14.68 million were spent to correct patient care deficiencies. The department did not establish a separate budget account to monitor funds specifically appropriated to comply with the decree. As a result, the department cannot determine if these funds were spent as intended by the General Assembly.

From FY 86-87 through FY 88-89, DMH was appropriated approximately $14.68 million to eliminate deficiencies found by the United States Department of Justice at South Carolina State Hospital. Of this amount, SCSH was appropriated $2.71 million, while the community mental health centers and other agency services were appropriated $7.03 million and $4.94 million, respectively.

These funds have been combined with other funds appropriated to SCSH and other departmental entities. A separate account could have been established to identify funds expended to comply with the consent decree. However, the department did not establish a separate budget account for funds specifically appropriated to comply with the decree.

Section 11-9-10 of the South Carolina Code of Laws states:

> It shall be unlawful for any monies to be expended for any purpose or activity except that for which it is specifically appropriated . . . .

When separate budget accounts or other mechanisms are not set up to monitor special appropriations, the department has less assurance that the funds are spent for their appropriated purposes and legislative intent may not be followed.

Transfer of Children's and Forensic Units

DMH and the Department of Justice have a different interpretation of a modification to the remedial action plan which transferred the children's and forensic units from SCSH to Hall Institute.

In a letter to the Department of Justice dated December 31, 1986, DMH stated that the transfer of these units to Hall Institute could better serve their patient populations and assist SCSH in meeting other requirements of the settlement agreement. The letter stated:

> The transfer of 40 children's and 108 forensic beds from South Carolina State Hospital to William S. Hall Psychiatric Institute constitutes a modification to the plan of action presented to the Court on June 24, 1986. In compliance with [Paragraph V.4] of the Settlement Agreement the attached modification is hereby submitted to the Department of Justice.

Section V.4 of the settlement agreement requires state officials to submit any modification to the remedial action plan to the Department of Justice. Further, the consent decree allows the Department of Justice 60 days to either comment on or object to a modification. The decree also requires that all modifications to the remedial action plan be filed with the federal court.

The Department of Justice did not comment on or object to the modification transferring the children's and forensic units within 60 days of its submittal by DMH. A DMH official stated that because a response was not received from the Department of Justice within 60 days, the agency assumed that the units were no longer a part of the remedial action plan and, thus, not under the purview of the Department of Justice. As a result, from October 1986 to October 1988, DMH did not submit reports of progress or compliance on these units to the Department of Justice, as required for all components of the remedial action plan. An official of DMH told us that the Department of Justice did not make any comment when DMH did not report on these units.

However, in a letter to the Audit Council dated October 11, 1988, a Department of Justice official stated:

> . . . although the children's and forensic units were administratively transferred . . . the U.S. Department of Justice considers that the provisions of the Consent Decree and the remedial action plan continue to apply to these two units.

According to a DMH employee, the agency became aware that the Department of Justice still considered these units as a part of the remedial action plan in September 1988.

If this issue cannot be resolved between the Department of Justice and DMH, the decision to determine whether the children's and forensic units must comply with the remedial action plan will be left to the federal court.

Recommendations

29 The Department of Mental Health should establish separate budget accounts or other mechanisms to monitor the expenditures of funds appropriated for specific purposes.

30 In accordance with the settlement agreement, the Department of Justice and DMH should attempt to resolve any differences concerning modifications to the remedial action plan.

The Mobile Crisis Program

The mobile crisis program (MCP) of the Charleston Area Mental Health Center was developed in part as a method to reduce inpatient psychiatric admissions in order to comply with the justice department consent decree. This program provides community-based psychiatric services to the Charleston area. Also, the MCP conducts psychiatric screenings at hospital emergency rooms in Charleston. Prior to the establishment of the MCP, the screening services were provided by existing center staff.

Since screening services were provided by existing mental health staff prior to the MCP, we reviewed the "mobile" component of the MCP. This component involves clinicians and MUSC psychiatrists or residents going to the scene of psychiatric emergencies. A team of two staff members drive to a crisis site

in one of two MCP vehicles to provide emergency treatment. We found that the program was not operating as intended.

Psychiatric Admissions

A major objective of the MCP was to lower psychiatric admissions from the Charleston catchment area. A review of DMH facility records revealed that psychiatric admissions during the first calendar year the MCP operated were 18% higher than admissions in the previous calendar year. During this time period, statewide psychiatric admissions only increased by 6%.

DMH and center officials stated that psychiatric admissions from the Charleston area may be even higher if the MCP did not exist. According to these officials, more people may need hospitalization than when the program started. Also, the MCP may be serving clients that would not have been seen before the program began.

Operating Hours

The MCP has not provided 24-hour, 365-day-a-year psychiatric coverage as designed. Since the program became operational in January 1988, it has either operated for a limited number of hours on a five-day or a seven-day basis. From January to December 1988, mobile services were offered from 8:30 a.m. to 5:00 p.m., Monday through Friday. Then, beginning in January 1989, services were expanded to 9:00 p.m., seven days a week.

According to MCP documents, from January 1988 to June 1989, a total of 598 community responses were conducted. Thus, after 18 months in operations, the mobile crisis staff was conducting fewer than 1.5 evaluations a day.

The director of the MCP in an April 1988 letter to the commissioner of DMH stated:

> . . . we hope that the Department can support our efforts to expand our staff so that we can truly be mobile on a 24-hour a day basis.

Nevertheless, a center official told us that additional funds are not available to expand the MCP. The center had a budget deficit of $60,000 in FY 88-89 and estimates a $440,000 deficit for FY 89-90.

Conclusion

Although this program to screen and treat mentally ill clients may be worthwhile, its cost effectiveness is questionable. Inpatient admissions have increased since the program was implemented, and few clients have been served. Other community mental health centers have functioned without this program.

Recommendations

31 The Department of Mental Health should study the clinical as well as the financial feasibility of continuing the mobile crisis program.

32 Prior to committing state funds for new programs, Department of Mental Health officials should ensure that funds are available.

PACT Implementation

We reviewed DMH's implementation of programs in assertive community treatment (PACTs). The department established the first PACT in February 1987 and three additional PACTs and two programs which are variations of PACTs between January 1988 and August 1988. These programs are designed to provide patients with intensive case management services to assist them in living in a community setting instead of an inpatient facility. The PACTs were set up as a means of reducing the census at South Carolina State Hospital in order to comply with the Department of Justice consent decree.

We found that PACTs have not significantly reduced the inpatient census at South Carolina State Hospital as intended. Also, the department did not adequately research and plan for medicaid reimbursements.

Census Reduction

DMH implemented PACT as one means to comply with requirements of the justice consent decree, specifically a reduction in the census of SCSH. The short range objective (from February 1987 to February 1988) of the first PACT was to reduce the census at SCSH by 120 clients. This objective was not achieved. As of October 1989, PACTs had reduced the census at SCSH by 45, 38% of the 120 patient reduction projected from the first PACT.

Further, according to DMH records, the success of the first program would determine whether other PACTs would be established. Nevertheless, the department established additional programs, even though the first PACT did not reduce the census at SCSH as intended.

Use of Optional State Supplement

DMH discontinued efforts to obtain additional medicaid funds for PACTs around the state because of inadequate information of the financial impact on the agency. As part of the department's efforts to finance the PACTs, DMH, in conjunction with the Department of Social Services (DSS) planned to expand the optional state supplement (OSS), a state-funded program providing income to qualified disabled individuals. Expansion of the optional state supplement to qualifying individuals would make them eligible for medicaid benefits and would automatically allow DMH to receive federal reimbursement for the services provided. However, DMH did not fully explore all costs involved in expanding the OSS and did not consider the reimbursement benefits.

Department officials knew when the PACTs were begun that the agency would have to reimburse DSS for the cost of expanding the OSS. However, they did not anticipate having to provide the state's share for medical services under the medicaid program

for individuals receiving OSS. After the agency became aware of this in January 1988, DMH conducted an impact study which estimated the cost of the medical services to be approximately $160,000 and $538,000 in FY 87-88 and FY 88-89, respectively. However, this was not done until after PACTs had begun operation. Because of the unplanned medical costs, the department discontinued its efforts to expand the OSS to individuals in the PACTs.

According to DMH records, an additional 73 of 241 (30%) patients in the PACTs, as of October 1988, would have become medicaid eligible with the OSS. However, no impact study was done comparing the total cost of expanding the OSS with the anticipated medicaid revenue that could be generated as a result.

Conclusion

Although PACTs may be worthwhile, they have been expanded even though their goal of reducing the census at South Carolina State Hospital by 120 clients has not been met. Proper financial research and planning are necessary in implementing new projects and should be done prior to program implementation. However, the department began PACTs before all cost factors had been considered.

Recommendations

33 The Department of Mental Health should study the financial feasibility of continuing the programs for assertive community treatment.

34 The Department of Mental Health should ensure adequate financial research and planning of all new programs.

Alcohol and Drug Treatment Services

The Department of Mental Health has expanded the involuntary alcohol and drug (A&D) abuse program beyond the General Assembly's intent. DMH has increased the number of beds devoted to involuntary A&D admissions beyond the number funded by the General Assembly, resulting in the department exceeding its appropriations for involuntary A&D services. Further, this has led to a reduction in services to voluntary A&D patients.

Since 1975, the department has operated a voluntary A&D facility at Morris Village. In 1986, the General Assembly passed legislation allowing for the involuntary commitment of alcohol and drug addicted individuals, beginning in January 1987. To begin implementing the new involuntary program in its inpatient facilities, DMH was appropriated $1,031,000 for FY 86-87.

Expansion of Beds

The department has provided more involuntary A&D services than funded by the General Assembly. According to documents provided by DMH and the Budget and Control Board, $1 million in new funds was appropriated for FY 86-87 to fund a 30-bed involuntary unit at Crafts-Farrow State Hospital to be operated by Morris Village. However, when the law went into effect, the department began placing involuntary commitments at Morris Village and never opened the 30-bed unit for A&D patients at Crafts-Farrow. Instead, the department opened involuntary A&D units at Harris and Bryan Hospitals and began detoxification services at Byrnes Medical Center. The total average daily census of 112 involuntary A&D patients in FY 86-87 rose to 173 during FY 87-88 then to 197 in FY 88-89.

Table 3.1: Average Daily Census of Involuntary A&D Patients by Facility

Facility	FY 86-87[a]	FY 87-88	FY 88-89
Morris Village	63	100	109
Harris Hospital	18	21	30
Bryan Hospital[b]	18	30	20
Byrnes Medical Center	13	22	38
Total	**112**	**173**	**197**

[a]Reflects only the first six months of the act, January through June 1987.
[b]Discontinued A&D admissions at the end of FY 87-88, although some clients were treated in FY 88-89.

Source: Department of Mental Health facilities

Section 44-52-110 of the South Carolina Code of Laws states that the courts shall not order commitment to DMH for A&D services unless it first determines that the agency has an available bed. However, rather than limiting the A&D beds to coincide with the amount of funding appropriated, the department decided to accept all involuntary admissions. This is because, according to DMH officials, the department originally estimated that it would need more beds for involuntary A&D admissions. Further, officials believed that if involuntary A&D beds were limited and the courts were unable to commit individuals under A&D statutes, they were likely to commit them under psychiatric statutes. This could lead to inappropriate admissions to psychiatric hospitals (see p. 17).

Expenditures Beyond Allocations

For the first full fiscal year of the program, FY 87-88, the General Assembly appropriated DMH $5 million for the inpatient A&D program. DMH allocated $1.68 million of these funds for involuntary services, based on an annualization of the $1 million appropriated for part of FY 86-87 for 30 involuntary A&D beds. However, involuntary A&D expenditures exceeded allocations by approximately $344,000 in FY 86-87, $4 million in FY 87-88, and $4.7 million in FY 88-89, (see Table 3.2). This resulted from DMH's expanding the involuntary A&D program beyond the General Assembly's intent.

Table 3.2: Involuntary A&D Allocations and Expenditures

Facility	FY 88-89 Allocations	FY 88-89 Expenditures
Morris Village	$858,413	$4,272,672
Harris Hospital[a]	880,626	1,360,579
Bryan Hospital[b]	•	•
Byrnes Medical	•	755,032
Contracts	400,000	443,916
Total	**$2,139,039**	**$6,832,199**

Facility	FY 87-88 Allocations	FY 87-88 Expenditures
Morris Village	$780,140	$3,045,862
Harris Hospital	455,626	594,436
Bryan Hospital[c]	•	1,213,451
Byrnes Medical	60,000	361,949
Contracts	388,273	388,273
Total[d]	**$1,684,039**	**$5,603,471**

Facility	FY 86-87 Allocations	FY 86-87 Expenditures
Morris Village	$789,373	$507,573
Harris Hospital	•	140,438
Bryan Hospital	•	196,866
Byrnes Medical	•	289,100
Contracts	242,202	242,202
Total	**$1,031,575**	**$1,376,179**

[a]Estimated expenditures.
[b]Expenditure information not available.
[c]Discontinued A&D admissions at the end of FY 87-88, although some clients were treated in FY 88-89.
[d]Does not include $30,000 allocated to Crafts-Farrow for involuntary A&D Services.

Source: Department of Mental Health facilities

Impact on the Voluntary Program

Because of the expansion of the involuntary program, services for voluntary A&D treatment have been reduced. Although Morris Village was built as a voluntary facility, by the end of FY 87-88, fewer than half of the facility's patients were voluntary admissions. Further, only 39% of the expenditures that year were made for the voluntary program.

In FY 85-86, when Morris Village was providing only voluntary A&D services, facility expenditures were approximately $4 million and the average daily census (ADC) was 128. For FY 87-88, facility expenditures were $5 million and the average daily census had risen to 162. However, only 39% (an ADC of 63) of the facility's patients were voluntary admissions. Approximately $1.9 million was spent on the voluntary program in FY 87-88, although $2.6 million had been allocated by DMH for those services.

Prior to implementation of the involuntary commitment law, the commissioner of mental health informed a joint legislative committee that more beds would be needed for the involuntary program. However, the commissioner also stated that voluntary beds at Morris Village would not be compromised for the involuntary program.

Conclusion

Because the department has not designated and funded a specific number of beds for involuntarily committed A&D patients, DMH is diverting funds from psychiatric programs and voluntary A&D services to cover costs for involuntary A&D clients. DMH officials also stated that some individuals, who could receive services voluntarily, are being committed involuntarily as a result of the limited number of voluntary beds.

Recommendation

35 The Department of Mental Health should consider designating a specific number of beds for involuntary A&D services based on the funds appropriated for such services. If more beds are needed, the agency should request additional funding from the General Assembly. Further, the department should consider not accepting admissions exceeding the number of available beds for involuntary services without additional appropriations.

Treatment for Children and Adolescents

The Department of Mental Health has not provided adequate community treatment programs for children and adolescents. As a result, these clients have been treated in the more restrictive setting of an inpatient psychiatric hospital when community treatment would have been more appropriate. Further, inpatient treatment has resulted in a housing problem at Hall Institute, the state's primary inpatient facility for children and adolescents. These issues are discussed in detail below.

Community Services for Children and Adolescents

According to department officials, the lack of community treatment programs for children and adolescents has increased the need for inpatient services. In addition, officials in five community mental health centers (Columbia, Greenville, Orangeburg, Lexington and Charleston) stated that if community resources such as family preservation and crisis stabilization had been available, some children and adolescents who were hospitalized could have been treated in the less restrictive environment of a center. For example:

- A 17-year-old who was having problems at home and a 15-year-old who threatened to commit suicide were hospitalized at Hall Institute because a community-based crisis stabilization program was not available. These adolescents were hospitalized for nine and ten days, respectively.

- A 15-year-old who had discipline problems received care in an inpatient facility because the community did not have a day treatment program. The client was hospitalized at Hall Institute for 11 days.

- An 11-year-old described as "out-of-control" by family members was hospitalized at Hall Institute for eight days because a crisis stabilization bed in the community was not available.

Section 20-7-20(D) of the South Carolina Code of Laws states:

> For children in need of services, care and guidance the State shall secure services . . . to serve the emotional, mental and physical welfare of children . . . in their homes or in the *least restrictive environment* possible . . . . *[Emphasis Added]*

Also, the National Institute of Mental Health recommends that the care for emotionally disturbed children should be community-based. According to the study, children should receive services in the least restrictive, most normative environment that is clinically appropriate. Further, the study indicates that inpatient hospitalization is typically the most expensive and the *most restrictive* service in the mental health system.

Provisos in the FY 87-88 and FY 88-89 appropriation acts state that all mental health centers should prioritize services for children. In addition, in FY 87-88, funding was to be used for crisis stabilization services for children. The amounts expended for community services for children during these years could not be determined.

From FY 86-87 to FY 89-90, DMH requested appropriations totalling $11.4 million for children services. Of this amount, approximately $1.3 million was appropriated. Also, the department has taken some measures to enhance community services for children and adolescents. However, additional treatment programs for this population are needed.

Overcrowding at Hall Institute

From August 1987 to December 1988, eight beds for children and adolescents were added to an adult ward of Hall Institute. This violated both a federal court order and a DMH directive.

According to agency officials, a 50% increase in children and adolescents admissions at Hall Institute from calendar year 1987 to calendar year 1988 resulted in a need to increase the bed capacity. However, an April 1984 South Carolina federal court order (separate from the Department of Justice court order) stipulated that patients 17 and under were to be separated "sight and sound" from adults. Also, DMH Directive 665-85 states that patients 15 and under cannot be hospitalized on adult wards.

Further, Alabama, Florida, Georgia, and Mississippi by law, policy or practice do not house children with adults.

Recommendations

36 The department should ensure that appropriate services for children and adolescents are available in the communities.

37 The department should discontinue housing children on adult wards.

Budget Deficits

From FY 84-85 to FY 88-89, DMH has incurred budget deficits in four of five years. These deficits, which ranged from $947,000 to $7.8 million, have totalled over $16 million (see Table 4.1). These deficits have occurred although the General Assembly appropriated increases in state funds from FY 84-85 to FY 88-89 of approximately $70 million, or 82% (see Table 4.2). Total appropriations of state funds to all state agencies increased by 50% over the same period. DMH is the only state agency that has received supplemental appropriations for budget deficits during these years.

Table 4.1: DMH Budget Deficits

Fiscal Year	Budget Deficit
84-85	$2,300,000
85-86	7,800,000
86-87	•
87-88	947,000
88-89	5,100,000
Total	**$16,147,000**

Source: Appropriation acts

Table 4.2: Increase in State Funds: FY 84-85 Through FY 88-89

Fiscal Year	Base Appropriations	Total Appropriations[a]	Increase in Appropriations	Percent Increase
83-84	$84,829,360	$84,829,360	•	•
84-85	95,622,362	96,672,362	11,843,002	14%
85-86	107,832,472	108,772,472	12,100,110	13%
86-87	129,261,042	129,261,042	20,488,570	19%
87-88	141,054,620	141,054,620	11,793,578	10%
88-89	154,454,067	154,554,067	13,499,447	9%
Total	**$628,224,563**	**$630,314,563**	**$69,724,707**	**82%[b]**

[a]Total appropriations include supplemental appropriations from surplus funds but do not include supplemental appropriations for budget deficits shown at Table 4.1.

[b]$\frac{\$69,724,707}{\$84,829,360} = 82\%$

Source: Appropriation acts

Analysis of Deficits

We analyzed the agency's deficits and found several causes. First, new programs have been started without sufficient funding. Second, DMH has provided more services than authorized by the General Assembly. In addition, there are costs beyond the control of DMH that impact on its budget. The following outlines areas which have led to budget deficits.

New Programs

DMH has started new community programs which have primarily expanded services rather than limit admissions to inpatient facilities. The agency's purpose for these new programs is to expand services in the communities in order to alleviate overcrowding at South Carolina State Hospital. While these programs may be worthy, their start-up and operating costs have contributed to the agency's deficits and have not significantly reduced the inpatient population at facilities. The following outlines three DMH initiatives which have contributed to its budgetary problems.

Mobile Crisis

As discussed in Chapter 3, DMH implemented the mobile crisis program to provide on-site emergency psychiatric services to the Charleston area. In FY 87-88 and FY 88-89 respectively, the mobile crisis program cost approximately $325,000 and $397,000 to operate. Between January 1988 and June 1989, 598 community responses were conducted by the mobile crisis staff, accounting for less than 1.5 evaluations per day for a professional staff of seven people. Further, the program has not reduced admissions to DMH inpatient facilities as intended. This program was started without specific legislative approval in a year in which the agency experienced a budget deficit (see p. 36).

PACT

As previously discussed, DMH established a community-based independent living skills program for DMH clients, the program for assertive community treatment (PACT), in 1987 and expanded the program through August 1988 (see p. 38). A total of four PACTs and one variation of PACT served approximately 241 clients in FY 88-89, costing over $2 million. The goal of the first PACT was to reduce the census at South Carolina State Hospital by 120 clients. However, as of October 1989, only 45 clients from South Carolina State Hospital had been served by PACTs. The programs have contributed to the agency's budget deficits but have not reduced the census at South Carolina State Hospital as intended.

Community Support Programs

In 1984, DMH shifted approximately $4.4 million from South Carolina State Hospital (SCSH) and Crafts-Farrow State Hospital (CFSH) to the communities for the development of community support programs. These programs were designed to reduce the need for inpatient hospitalization.

DMH identified 600 patients in SCSH and CFSH who did not require inpatient hospitalization and paid the community centers $20 per day to provide treatment for these patients ($20 x 365 days x 600 patients = $4,380,000). In documents filed with the Budget and Control Board, DMH officials stated that the inpatient census has not decreased as rapidly as was projected, and the community support programs have expanded the population served. A review of DMH census records also indicates that the census has not significantly declined. Thus, while $4.4 million was permanently reallocated from two inpatient facilities, inpatient expenditures did not decrease enough to balance DMH's budget.

DMH has expanded community programs because the consent decree required either a census reduction or increased staffing at South Carolina State Hospital; therefore, funds appropriated to comply with the consent decree provided for expansion in the communities. However, DMH has not sufficiently reduced the overall inpatient census and, thus, expenditures have increased while new programs have been implemented in the communities.

Program Increases

The following outlines several ways in which the agency expanded services when facing budget problems.

Involuntary Alcohol and Drug Law

DMH has provided more involuntary alcohol and drug services than it has funding for. In FY 86-87, the General Assembly provided funding for 30 involuntary alcohol and drug beds and specifically allowed the department to refuse admissions. DMH has not set a limit on the number of beds, however, and the average daily census of involuntary alcohol and drug patients rose to 197 during FY 88-89. Involuntary alcohol and drug expenditures exceeded state appropriations by $344,000 in FY 86-87, by approximately $4 million in FY 87-88 and by an estimated $4.7 million in FY 88-89, contributing to the agency's budget deficit (see p. 41).

New Staff Hired

At the beginning of FY 88-89, DMH administrators recognized that the agency faced a budget deficit of over $3 million. In an effort to absorb this deficit, DMH requested the centers and facilities to develop a plan to operate with a reduced budget. However, neither the centers nor the facilities developed such a plan.

Notwithstanding the impending deficit, the agency did not cut programs or take sufficient steps to reduce its budget. Further, at the beginning of FY 88-89, the agency increased its staff size by 49 employees at a cost of approximately $1.2 million. For FY 88-89, the agency was provided 74 new positions and approximately $2.4 million to hire additional positions. Limiting the hiring of additional personnel when a deficit is pending is one mechanism which could be used by DMH to limit costs.

In January 1989, DMH reported to the Budget and Control Board that it projected a deficit of $6.5 million, and ended the year with a $5.1 million deficit.

Costs Beyond DMH Control

DMH has experienced problems with inappropriate admissions (see p. 17). Clients who are not in need of psychiatric care or could be better cared for in the communities are committed to DMH facilities. Between May 1988 and July 1988, 187 of 2,821 admissions could have been better served in communities. Reducing inappropriate admissions could help to reduce the agency's inpatient census and help balance its budget.

Outdated Financial System

A review of the financial system at DMH found that the current system adversely affects operations at DMH.

In December 1986, the Department of Mental Health contracted with an accounting firm to provide consultant services. The firm issued its report in April 1988. In its summary of findings and

recommendations, the accounting firm identified major findings including the following:

- Personnel costs are not tracked at a level of detail necessary to develop accurate expenditure forecasts.
- Physician consultation and ancillary service records are manually maintained in a format insufficient to support billing to medicaid, leading to the conclusion that many billable services are not being recovered.
- The current chart of accounts cannot track expenses by program.
- There is no capability to budget by month, thus reflecting historical expenditure patterns.
- There is no process in place to encumber funds at the time a purchase order is generated.
- There is no ability to tie budget request amounts and actual expenditures to operating performance measures.
- There is no ability to explain variations in month-to-month forecasts of budget position, and, in general, the forecasting process is manual in nature.

According to the report, annual benefits of a new financial system would consist of a continued increase in revenue collection of $3,650,000 for inpatient facilities, clinical labor savings of $900,000, and administrative labor savings of $320,000 for a total annual return of $4,870,000. The report further stated that additional quantitative benefits could be realized through increased revenue billings and collections in the community mental health centers.

DMH has requested funding for computer equipment in its budget requests in FY 85-86, FY 87-88, FY 88-89 and FY 89-90. For FY 89-90, the Budget and Control Board recommended that the General Assembly provide $1,779,510 to fund "first year costs out of a total of $5,456,698 spread over a period of four years based on figures provided by Information Technology."

Staff Recommendations for Deficit Avoidance

At the beginning of FY 88-89, DMH formed a budget committee to make recommendations for deficit avoidance. The group made 15 recommendations to save approximately $3.4 million. Recommendations included moving 75 patients to community nursing homes, at an estimated cost savings of $560,000; eliminating current selected grants and initiating no new grants requiring state matching funds for a savings of $492,000; eliminating the mobile crisis program for an estimated savings of $400,000; and transferring 30 Columbia PACT clients to the Columbia Area Mental Health Center for an estimated savings of $350,000.

Management implemented three recommendations for a savings of $363,000 and partially implemented two others. Cost saving measures implemented included cancelling the quarterly director's meeting for an estimated cost savings of $13,100, closing 44 beds at Tucker Center for an estimated cost savings of $250,000, transferring 104 patients over a three-year period to the Department of Mental Retardation for an estimated cost savings of $100,000 and closing the alcohol and drug unit at Bryan Hospital (no cost savings were provided).

However, after the alcohol and drug unit was closed at Bryan Hospital, the Commission voted to expend an extra $800,000 to reopen the unit for psychiatric purposes, thus no cost savings were realized in this area. Also, the 44-bed ward at Tucker Center was reopened in August 1989 in order to transfer patients needing acute care from other facilities.

DMH also closed the geriatric unit at Harris Hospital in another action to help avoid a deficit, although this was not a recommendation made by the budget committee.

The majority of staff recommendations to save funds were rejected. However, no documentation exists outlining why these cost-saving measures were not implemented.

DMH officials have indicated that they are concerned about budget deficits and have expressed that DMH intends to end FY 89-90 without incurring a deficit. For example, operating centers and facilities within budget allocations has recently been

incorporated into the performance evaluation for each facility and center director. According to a letter issued by the commissioner, "failure to operate a facility or center within budget will result in formal administrative disciplinary action in accordance with the progressive discipline system."

Review of Reasons Provided by DMH for Deficits

We reviewed supplemental budget requests that DMH submitted to the Budget and Control Board from FY 84-85 to FY 88-89 and found that many factors cited for the $5.1 million deficit in FY 88-89 are the same factors cited for the $7.8 million deficit in FY 85-86. DMH balanced its budget in FY 86-87, indicating that it can operate within its appropriated budget. However, the agency continues to cite events which took place in the early to mid 1980s as causes of its deficit in FY 88-89. By operating within its budget in FY 86-87, the agency established a base which indicates it can operate within its appropriations.

For example, in both FY 85-86 and FY 88-89, DMH cited a shift of $4.4 million from South Carolina State Hospital and Crafts-Farrow State Hospital to the communities for the development of community support programs as one cause of its deficits. While this shift affected the agency's budget, DMH was able to balance its budget one year after the shift, indicating that it could operate within its appropriated budget that year.

In FY 85-86, DMH cited opening Harris Hospital, a 206 bed psychiatric hospital with an operating budget of $7,668,000 with only $2,000,000 of new funding; adding 300 nursing home beds at Tucker Center in FY 82-83 with no new funds; and opening a 430 bed facility (Dowdy-Gardner) in Columbia and Rock Hill with no new funds. Although DMH balanced its budget after these new programs were started, the agency cited these factors as reasons for its deficit in FY 88-89.

Conclusion

While appropriations have increased by $70 million in five years, the department has not been able to operate within its budget, and repeatedly seeks supplemental appropriations at the end of the year to balance its budget. DMH management must be committed to operating within its budget. The agency should define its base operations and allocate funds to operate at that base. If additional programs or services are warranted, they should be approved in advance by the General Assembly.

Recommendations

38 DMH should prepare an operating plan which allocates funds for its programs at the level of appropriations obtained from the General Assembly.

39 DMH should obtain approval and funding for major new or expanded programs from the General Assembly prior to implementing the programs.

40 DMH should, where possible, avoid refilling facility beds as it moves patients out into the communities, so that DMH avoids overcrowding in its facilities and balances its budget.

41 The General Assembly may wish to consider continuing funding a new management information system for DMH.

Agency Comments

DMH South Carolina Department of Mental Health

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Joseph J. Bevilacqua, Ph.D.
State Commissioner

March 8, 1990

Mr. George L. Schroeder
Director
Legislative Audit Council
400 Gervais Street
Columbia, South Carolina 29201

Dear Mr. Schroeder:

Thank you for allowing us to respond to the **Legislative Audit Council's Review of Compliance With Our 1983 Audit of the Department of Mental Health and Other Issues.** Our comments are attached.

The Department of Mental Health agrees, in whole or in part, with 40 of the 41 recommendations made by the audit council. We have provided a list outlining our view of the recommendations.

The Department of Mental Health is gratified that the audit council noted substantial improvements since its 1983 audit.

Sincerely,

Joseph J. Bevilacqua, Commissioner

attachments

DMH RESPONSE TO LAC REPORT

The Department of Mental Health is in general agreement with the conclusion (see Executive Summary) reached by the LAC, and specifically agrees, in whole or in part, with 40 of the 41 recommendations.

The Department of Mental Health is appreciative of the efforts of the auditors and authors of this report. We offer these comments to clarify the findings, which though technically accurate, may be misinterpreted by those unfamiliar with the context of treatment for the seriously mentally ill.

This document will provide the needed context to put the audit council's report into perspective.

The Department of Mental Health is in substantial agreement with most of the LAC recommendations (see attached list) but has, as might be expected, some differences of interpretation.

The 1980s were a difficult time for the Department of Mental Health. In 1983, the U.S. Justice Department came to the state to examine conditions at South Carolina State Hospital. In June, 1986, the Justice Department entered into a consent decree with the state of South Carolina and the Department of Mental Health. The involvement of the federal judiciary, and the threat of widening involvement, has become a part of the decision processes related to budget priorities, patient services and program responsibility.

The last half of the 1980s was characterized by a heightened level of activity. No division, institution or functional area of the Department of Mental Health looks in 1990 the way it did in 1983, when the LAC conducted its previous comprehensive audit of the agency. The department has consistently focused its efforts on moving the site of treatment from central institutions to the community.

The Department of Mental Health is gratified that the LAC noted improvements since its 1983 visit. Key improvements noted in the 1990 report include:

* "Substantial progress" in correcting deficiencies found in the handling of patient abuse and patient sexual abuse cases.
* Better supervision of patients.
* Fewer patients leaving DMH campuses without permission.
* Community screening by mental health centers has helped reduce inappropriate admissions to inpatient facilities.
* Community mental health center expenditures have increased at a higher percentage than inpatient expenditures.
* Improved discharge planning.
* Security operations have been centralized.
* Improved debt collections at community mental health centers.

Throughout the last five years, the General Assembly has supported improvements in the care and treatment of the mentally ill. Its standing committees have brought forward statutory changes to support the shift to the community. Though always reluctant to condone any deficit, both House and Senate budget committees have endorsed supplemental appropriations to cover potential deficiencies so that services could improve for patients and their families.

Legislative support has been based upon visible and tangible improvement in the quality of care and in the quality of management, which is underscored by the latest LAC findings.

The department wants to enhance its credibility with the General Assembly by showing fiscal responsibility as well. DMH management is committed to stabilizing the agency's budget. Painful measures have been taken this fiscal year toward that end. Facility and center directors have been put on notice that their job performance will be evaluated, in part, on their ability to operate their facility within budget. A new emphasis on fiscal responsibility can be seen throughout the agency.

As always, the demand for services exceeds the amount of funds needed to provide them. The LAC report points out the "Catch-22" dilemma the department

continually faces.

On the one hand, the LAC criticized the department for spending more for alcohol and drug treatment services than the General Assembly appropriated.

On the other hand, the LAC said the department isn't providing enough community services for children and adolescents. The LAC acknowledged DMH has not received the funds for child and adolescent services it has requested over the years from the General Assembly, and yet the council recommended the department "ensure that appropriate services for children and adolescents are available in the communities." DMH agrees, but can't provide them without money.

The findings published in 1990 are but a snapshot -- a static picture that cannot adequately capture the process underway at DMH to provide the best patient care possible. Some new programs noted in the report have not yet passed muster. However, the Department of Mental Health management, with strong local support, and convincing evidence from other states, remains committed to these programs such as PACT, Mobile Crisis, and Elder Support.

In its examination of the Mobile Crisis Program (MCP), the LAC concluded that admissions from the Charleston Area Mental Health Center increased 18 percent during calendar year 1988, the first year the program was in operation. It is not uncommon for a new service such as the Mobile Crisis Program to increase service demand slightly at its inception because of a phenomenon called "case finding." Because of its responsiveness, the new program or service turns up people in need who were previously not identified.

We believe that this is what happened with the MCP during its first year. During the next calendar year, 1989, statewide admissions increased by 8 percent, while those for Charleston held steady for the full year. There was actually a decrease of less than 1 percent for that year.

A projection based on the first eight months of this fiscal year -- July 1, 1989 through February 1990 -- is encouraging: admissions statewide are projected to continue at a modest rate of increase (4 percent), while Charleston is projected to show a net decrease (16 percent). We believe that the trend lines for both Charleston

and the state reflect the impact of new ways of treating the mentally ill.

But there is another, more human issue aside from whether the MCP decreases admissions to state psychiatric facilities. Most clinicians and administrators associated with this service believe that people who experience a psychiatric emergency are more effectively served on an outreach basis. The number of lives spared and the amount of misery alleviated by taking psychiatric services to the site of potential human disasters cannot be calculated, but should not be ignored.

The audit report also examined the four PACTs (Programs for Assertive Community Treatment) begun in South Carolina. The PACT model is nationally recognized for its ability to drastically reduce the amount of time those served by these programs spend in hospitals. Even more important is the improved quality of life these individuals experience.

Only three PACTs have been developed to help reduce the census at South Carolina State Hospital (SCSH) -- one in Columbia, which was the first one, and two at the Charleston Area Mental Health Center. In addition to reducing hospital census, PACTs help keep clients in their community, thus minimizing disruption of their lives.

The Columbia program has taken 24 patients from SC State Hospital and the two Charleston programs have taken 23 and 17 patients -- an overall total of 64 patients from SCSH. In addition, the other 100 patients in these three programs all have a history of multiple, and sometimes lengthy, hospital admissions. These three programs report a reduction in state hospital days for their patients of 85 percent to 95 percent since enrolled in the programs.

An additional PACT was developed to reduce the census at Crafts-Farrow State Hospital. This program has taken 18 elderly patients from that hospital, many of whom had been there for many years. Since the start of the Elder Support Program in early FY 88-89, hospital use by these patients has been reduced by 98 percent.

Certainly the national experience and literature indicates what we already know: South Carolinians served by PACT, Elder Support and other new community

programs enjoy a higher degree of individualized care, and thus a better quality of life.

DMH management agrees with the LAC's recommendations to study the clinical as well as the financial feasibility of continuing the mobile crisis and assertive community treatment programs.

Admission trends in South Carolina give us hope that DMH will have findings similar to those in five national studies that tested the rationale for a community-based approach to the treatment of schizophrenia. The findings of these five studies were noted in an article written by Dr. Leonard Stein and published in the September 1987 edition of Psychiatric Annals (p. 597), a prominent, national journal.

> "Both clinically and economically, five studies done in different sites all come to similar conclusions -- a relatively rare phenomenon in this field. These studies show that comprehensive community-based treatment, which provides excellent clinical results, costs only about one-fourth the price of long-term institutional care. Furthermore, these studies all show that the cost of this community-based care is about the same as what we are already paying for the poor results that we are getting from our present revolving-door system."

Actions of the General Assembly have resulted in other dividends to our patients. Advocates can, and do, enter our facilities for unannounced inspections. All patient abuse allegations are referred to SLED. Quality Assurance is a deeply ingrained process department wide. Alcohol and drug patients now receive treatment appropriate to their disease, and are no longer warehoused on wards for the mentally ill.

A note on LAC findings related to alcohol and drug treatment services is needed. The LAC report concluded that DMH has expanded the involuntary alcohol and drug (A&D) abuse program beyond the General Assembly's intent. Some perspective is necessary.

The report referred to a 30-bed unit for treating involuntary A&D patients. This was an early planning estimate used by the state Budget and Control Board in discussions about the number of beds needed to serve this population if the state

passed an involuntary commitment law for chemically dependent persons.

That ceiling was not mandated in the appropriations act when the involuntary commitment law for chemically dependent persons was passed. The involuntary commitment act ordered DMH to establish a "comprehensive, coordinated" program of treatment services for chemically dependent persons. In response to this legislative mandate, alcohol and drug patients now receive treatment specific to their illness.

DMH continues to assert that accepting all chemically addicted clients is preferable to having those patients inappropriately admitted to psychiatric hospitals -- a circumstance in which the addicted patient does not receive appropriate treatment and in which scarce resources for the psychiatrically disabled are misapplied.

Over the years, the commitment of the General Assembly ultimately has resulted in adequate funding for the Department of Mental Health to execute its statutory responsibility. According to the Justice Department, that was not the case in the first half of the 1980s. The Department of Mental Health in 1990 is facing, successfully, the enormous challenges of balancing a budget while simultaneously improving the quality of care.

Dr. Llewellyn Bigelow, consulting psychiatrist for the U.S. Justice Department said in 1988:

> "I emphasize that nowhere did I find the kinds of attitudes and lack of controls that could lead to an institutional acceptance of the kinds of abuse reported in the 1970s and early 1980s. It is a tribute to the leadership and staff of the hospital and to the state that the problems discovered have been aggressively pursued and eliminated."

The Department has emerged from the turbulence of the last decade with a new look, a new set of priorities, and a new vision. Decisions at the Department of Mental Health are characterized by openness, accountability, citizen participation, fiscal responsibility and uncompromising insistence on the protection of the rights of our patients.

We will, with these values, carefully plan and implement a process of transition to individualized, community-based services, tailored to protect the rights and freedom of South Carolina's mentally ill citizens and their families.

The 1983 report of the LAC was in many ways a catalyst for all of this. The 1990 report of the LAC is a testimony that the Department of Mental Health is moving in the right direction.

DMH'S RESPONSE
TO LAC RECOMMENDATIONS

I. CHAPTER II RECOMMENDATIONS (FOLLOW-UP OF 1983 AUDIT)

A. PATIENT ABUSE INVESTIGATIONS

Recommendation 1 -- DMH agrees.

Recommendation 2 -- DMH agrees.

B. INQUIRY AND REVIEW BOARDS

Recommendation 3 -- DMH agrees with the intent of this recommendation. We will consider developing operational standards for the use of outside people to serve on boards of inquiry, as needed.

Recommendation 4 -- DMH agrees.

Recommendation 5 -- DMH agrees with excluding employees involved in an incident from the board, however, DMH does not believe that the management of a facility or center should be prohibited from serving on boards. Medical staff at the management level are required to participate in internal review processes under JCAHO standards.

Recommendation 6 -- DMH agrees.

C. PATIENT SECURITY

Recommendation 7 -- DMH agrees.

Recommendation 8 -- DMH agrees.

Recommendation 9 -- DMH agrees.

Recommendation 10 -- DMH agrees.

D. ALCOHOL AND DRUG USE AT DMH FACILITIES

Recommendation 11 -- DMH agrees.

E. MORRIS VILLAGE SECURITY

Recommendation 12 -- DMH agrees and has drafted revisions which have been introduced as HB4240.

Recommendation 13 -- DMH agrees with improving fencing and lighting improvements and is studying the distribution of public safety officers.

Recommendation 14 -- DMH agrees.

F. PATIENT MANAGEMENT

Recommendation 15 -- DMH agrees.

Recommendation 16 -- DMH agrees.

Recommendation 17 -- DMH agrees.

Recommendation 18 -- DMH agrees.

G. TRAVEL TO PROBATE HEARINGS

Recommendation 19 -- DMH agrees.

H. NOTIFICATION OF CORONERS

Recommendation 20 -- DMH agrees.

I. CONFISCATED PROPERTY

Recommendation 21 -- DMH agrees.

Recommendation 22 -- DMH agrees.

J. DEPARTMENT HOUSING

Recommendation 23 -- DMH agrees the proviso should be changed.

K. DEPARTMENT SURPLUS LAND

Recommendation 24 -- DMH agrees in principle. However, DMH hopes to use any surplus land to help finance building new community facilities or to replace aging patient care areas in existing facilities.

L. COMMUNITY MENTAL HEALTH CENTERS -- FUNDING FORMULA

Recommendation 25 -- DMH agrees if provisions can be made to allow the department to deviate from the formula for just cause.

Recommendation 26 -- DMH agrees.

K. CMHC -- DISCHARGE PLANNING

Recommendation 27 -- DMH agrees.

L. COMMUNITY MENTAL HEALTH CENTERS -- COST VARIANCE REPORTS

Recommendation 28 -- DMH agrees.

II. CHAPTER III -- CLIENT SERVICES

A. JUSTICE CONSENT DECREE

Recommendation 29 -- DMH agrees.

Recommendation 30 -- DMH agrees. We believe that differences have been resolved.

B. MOBILE CRISIS UNIT

Recommendation 31 -- DMH agrees. DMH believes it is too early to make a definitive benefit/costs analysis of the Emergency Psychiatric Service, and so

support the recommendation of continuing to assess this program along both clinical and fiscal dimensions.

Recommendation 32 -- DMH agrees.

C. PACT IMPLEMENTATION

Recommendation 33 -- DMH agrees.

Recommendation 34 -- DMH agrees.

D. ALCOHOL AND DRUG TREATMENT SERVICES

Recommendation 35 -- DMH disagrees. DMH does not believe that a fixed number of beds serves the needs of the chemically addicted citizens of the state. Further, a patient's commitment status -- voluntary or involuntary -- is only one of the relevant criteria for accepting or rejecting an admission. The department currently does not accept admissions if beds are not available.

E. TREATMENT FOR CHILDREN AND ADOLESCENTS

Recommendation 36 -- DMH agrees, but notes that it cannot provide significantly increased services without funding to support the increase.

Recommendation 37 -- DMH agrees that children should not be housed with adults. The department does not house children on adult wards, but does have the prerogative to house certain consenting adolescents (aged 16-17) in any facility other than the adult forensic unit.

III. CHAPTER IV -- BUDGET DEFICITS

Recommendation 38 -- DMH agrees.

Recommendation 39 -- DMH agrees.

Recommendation 40 -- DMH agrees.

Recommendation 41 -- DMH agrees.

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